

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on March 29, 2004.

The IRO therapeutic exercises (97110) rendered from 04/30/03 through 08/08/03 were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

The **therapeutic exercises (97110) for dates of service 07/16/03 and 08/06/03** were found to be medically necessary. The **therapeutic exercises (97110) for dates of service 04/30/03 through 07/10/03, 07/17/03 through 08/01/03, 08/07/03 and 08/08/03** were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the therapeutic exercises.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 25, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 95999-WP (6 units) for date of service 05/07/03 denied as "D". The carrier has not submitted convincing evidence this CPT code is a duplicate; therefore, the disputed date of service will be reviewed according to the 1996 Medical Fee Guideline. According to the CPT descriptor there is no MAR for this code. Per the 1996 MFG, General Instructions (III)(A)(1-3) the requestor did not submit relevant information to support the services were rendered as billed. Reimbursement is not recommended.
- CPT Code 99213 for date of service 07/01/03 denied as "F". Per The 1996 Medical Fee Guideline, Evaluation & Management (VI)(B) reimbursement in the amount of \$48.00 is recommended.
- CPT Code 99213 for dates of service 08/06/06 through 08/27/03 denied as "F" and "Y, JM - Accurate coding or services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid. Please refer to the applicable medical fee guideline and/or Medicare

- guideline for the correct code or modifier for the service rendered". The requestor listed the amount in dispute for date of service 08/06/03 as \$61.82. Per the Medicare Fee Schedule in
- Tarrant County is \$50.25, times the 125% MAR for an office visit equals \$62.81. Per the Medicare Fee Schedule and Ingenix Encoder.Pro CPT code 99213 is a correct code for an office visit. Per Rule 133.202(c)(1) reimbursement in the amount of \$124.82 is recommended.
- CPT Code 97750-MT for date of service 07/10/03. An EOB was not submitted by neither the requestor or respondent, therefore, these dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of \$43.00.
- CPT Code 97750-MT for date of service 08/14/03. An EOB was not submitted by neither the requestor or respondent, therefore, this date of service will be reviewed in accordance with Commission Rules. Per Rule 133.307(e)(2)(A) the requestor did not submit a HCFA-1500 and it can not be determined if services were rendered as billed.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 07/01/03 through 07/16/03, 08/06/03, 08/14/03 and 08/27/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision & Order is hereby issued this 8th day October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

May 3, 2004

DONNA AUBY
TEXAS WORKERS' COMPENSATION COMMISSION
AUSTIN, TX 78744-1609

CLAIMANT:

EMPLOYEE:

POLICY:

MDR Tracking #: M5-04-2349-01

IRO #: 5278

Medical Review Institute of America (MRloA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRloA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRloA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRloA for independent review.

Records Received:

Submitted by Requestor

Notification of IRO Assignment dated 4/21/04 – 1 page

TWCC memo dated 4/21/04 – 1 page

Medical dispute resolution request/response – 4 pages

EOB forms – 14 pages

Submitted by Respondent

Letter from Main Rehab and Diagnostics dated 4/26/04 – 4 pages

Examination dated 4/23/03 – 4 pages

Right shoulder x-ray report dated 5/10/03 – 1 page

Lumbar MRI report dated 5/22/03 – 2 pages

Letter from Main Rehab and Diagnostics dated 6/24/03 – 2 pages

Report from Myron Glickfeld DO dated 6/25/03 – 2 pages

Electrodiagnostic report from Robert Lowry dated 7/1/03 – 2 pages

Range of motion report dated 4/24/03 – 1 page

Range of motion report dated 7/9/03 – 7 pages

Muscle strength testing reports – 20 pages

Progress notes – 14 pages

Report from Main Rehab and Diagnostics dated 8/29/03 – 3 pages

Check from Central Dallas Rehabilitation & Diagnostic Center, LLC – 1 page

Summary of Treatment/Case History:

The patient in this case was injured on the job on ___ when he was working 40' high and he was trying to climb up a sign to weld when he had to step on a board, which broke and caused him to lose his balance. He grabbed a side rod with his right arm and he also twisted his back. He began to experience severe right shoulder pain and back pain as the result of his injury and he presented to the chiropractor on 4/23/03 for evaluation and treatment. Right shoulder ranges of motion were reduced and shoulder orthopedic tests were positive for a potential impingement syndrome. The patient began a course of physical therapy.

The patient was treated with therapeutic exercises on the following dates: 4/30/03, 5/1/03, 7/1/03, 7/10/03, 7/16/03, 7/17/03, 7/18/03, 7/22/03, 7/23/03, 7/24/03, 7/25/03, 7/30/03, 7/31/03, 8/1/03, 8/6/03, 8/7/03, and 8/8/03.

Questions for Review:

1. Items in dispute: CPT Code #97110 was denied by the carrier for medical necessity. Do you agree with the carrier on the denial? Please explain why.

Do not review DOS 5/7/03, OV for 7/1/03, FCE for 7/10/03, OV for 8/6/03, or DOS 8/14/03 and 8/27/03.

Explanation of Findings:

1. Items in dispute: CPT Code #97110 was denied by the carrier for medical necessity. Do you agree with the carrier on the denial? Please explain why.

The denial for therapeutic exercises (#97110) was appropriate for the following dates of service: 4/30/03, 5/1/03, 7/1/03, 7/10/03, 7/17/03, 7/18/03, 7/22/03, 7/23/03, 7/24/03, 7/25/03, 7/30/03, 7/31/03, 8/1/03, 8/7/03, and 8/8/03. The medical records reviewed did not support the medical necessity for therapeutic exercises billed on the above-mentioned dates. The progress notes contained a generic statement regarding the number of units of therapy rendered, but the progress notes reviewed contained no usual and customary data to document the procedures performed. The "procedure" section of the SOAP notes contained no specifics related to the following usual and customary chart entries:

- Type of exercise(s) utilized
- Increases in repetitions
- Increases in weight moved during exercise
- Increases in range of motion
- Increases in endurance

Haldeman et al indicated that the patient's records must be sufficiently complete to provide reasonable information requested by a subsequent healthcare provider, insurance company, and/or attorney. A dated record of what occurred on each visit and any significant changes in the clinical picture or assessment, or treatment plan need to be noted (*Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993*).

The denial of therapeutic exercises (#97110) was inappropriate on 7/16/03 and on 8/6/03. The medical records reviewed adequately documented the exercise procedures utilized on these dates of service.

Conclusion/Decision to Certify:

Therapeutic exercises (#97110) were medically necessary on 7/16/03 and 8/6/03.

Decision to Not Certify:

Therapeutic exercises were not medically necessary on 4/30/03, 5/1/03, 7/1/03, 7/10/03, 7/17/03, 7/18/03, 7/22/03, 7/23/03, 7/24/03, 7/25/03, 7/30/03, 7/31/03, 8/1/03, 8/7/03, and 8/8/03.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993

References Used in Support of Decision:

CPT Code Book

This review was provided by a Doctor of Chiropractic who is also a member of the American Chiropractic Academy of Neurology. This reviewer also holds a certification in Acupuncture. This reviewer has fulfilled both academic and clinical appointments and currently serves as an assistant professor at a state college, is in private practice and is a director of chiropractic services. This reviewer has previously served as a director, dean, instructor, assistant professor, and teaching assistant at a state college and was responsible for course studies consisting of clinical neurology, pediatric and geriatric diagnosis, palpation, adjusting, physical therapy, case management, and chiropractic principles. This reviewer is responsible for multiple postgraduate seminars on various topics relating to chiropractics and has authored numerous publications. This reviewer has participated in numerous related professional activities including work groups, committees, consulting, national healthcare advisory committees, seminars, National Chiropractic Coalition, media appearances, and industrial consulting. This reviewer has been in practice since 1986.

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